

## CHAPTER II

### Methodology

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As described in the previous section, the needs and capacity assessment is guided by a set of health and well-being outcomes for the MCH population. These outcomes describe what is desired for Idaho's MCH populations, and the information collected will describe “how well” Idaho is meeting each of them.

The Needs Assessment Team used a multifaceted approach to gathering, analyzing, and reporting data and information that included qualitative and quantitative research. Critical to the approach was the development of mechanisms to obtain stakeholder feedback about the findings and opportunities to engage stakeholders in decision making about MCH priorities.

Data collection strategies included:

- Review of existing secondary documents with information and data concerning the status of the health and well-being of pregnant women, infants, children, adolescents, children with special health care needs, and families
- Review of data related to the level of capacity of the providers, programs, and systems that serve these population groups
- Collection of primary data, including key informant interviews, focus groups with families, and a survey containing options tailored to particular subcategories of the MCH population groups (e.g., prenatal, children with special health care needs)
- Analysis of data at the State and regional district levels to examine population needs and the relationships among needs, infrastructure, and services
- Conduct of three regional stakeholder sessions to present assessment findings and seek input into the recommendations
- Organization of an MCH advisory group comprised of stakeholders from community-based organizations, professional associations, BOCAPS, and other Department of Health and Welfare programs
- Collaboration with BOCAPS and other stakeholders (via Web-based efforts and through collaboration with BOCAPS systems partners) to identify internal capacity and MCH priorities.

The ultimate goals of this process, as articulated in the Idaho Department of Health and Welfare's Strategic Plan, are to improve the health status of the MCH population; to strengthen individuals, families, and communities; and to integrate health and human services.

## A. Secondary Data

Secondary data is information *about* the study group that is gathered, compiled, and reported by others. In the course of this needs assessment, the secondary data sources included health and surveillance data, program data, and survey data. Examples of datasets examined include:

### 1. Vital Records

Records from birth and death certificates are essential in assessing perinatal health, as they are the source for such indicators as low-birth-weight (LBW) and preterm birth rates, infant mortality rates, congenital anomalies identified at birth, and timing of initiation of prenatal care. In general, year 2002 or an average of years 2001- 2003 was used in this analysis.

### 2. Program Data

Programs within the Department of Health and Welfare, local district health departments, and other agencies have information about their clients' risk factors, health status, and use of services that are helpful in creating a picture of MCH needs in Idaho. Family Planning, WIC, Women's Health Check, Oral Health, Children's Special Health Program, and other program data were relied on for this assessment.

### 3. Survey Data

The table below is a summary of the national and State surveys used for this needs assessment.

<b>Table II-1. Youth Risk Behavior Surveillance (YRBS)</b>	
<b>Purpose</b>	<b>Methodology</b>
YRBS monitors six categories of priority health risk behaviors among children and young adults—behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection; unhealthy dietary behaviors; and physical inactivity—plus overweight.	Students complete the self-administered questionnaire during one class period and record their responses directly on a computer scannable questionnaire booklet or answer sheet. Before the survey was conducted, local parental permission procedures were followed.

<b>Table II-1.</b> <b>Youth Risk Behavior Surveillance (YRBS)</b>	
<b>National Survey on Children with Special Health Care Needs</b>	
<b>Purpose</b>	<b>Methodology</b>
<p>The primary goal of this survey is to assess the prevalence and impact of special health care needs among children in all 50 States and the District of Columbia. This survey explores the extent to which CSHCN have medical homes, adequate health insurance, and access to needed services. Other topics include care coordination and satisfaction with care.</p>	<p>More than 3,000 households with children were screened in order to identify 750 children with special needs in each State. Interviews were conducted with their parents. Also, brief health insurance interviews were conducted for children without special needs to estimate State-level health care coverage using equivalent-sized samples in each State. Finally, for uninsured children from low-income households, questions about parents' awareness of and experience with Medicaid and the state Children's Health Insurance Program (CHIP) were asked.</p>
<b>Pregnancy Risk Assessment Monitoring System (PRAMS)</b>	
<b>Purpose</b>	<b>Methodology</b>
<p>PRAMS is a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments. PRAMS collects State-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy. Thirty-one states and New York City currently participate in PRAMS. Four other states previously participated. This survey is used for national comparisons.</p>	<p>The PRAMS sample of women who have had a recent live birth is drawn from the State's birth certificate file. Each participating State samples between 1,300 and 3,400 women per year. Women from some groups are sampled at a higher rate to ensure adequate data are available in smaller but higher risk populations. Selected women are first contacted by mail. If there is no response to repeated mailings, women are contacted and interviewed by telephone. Data collection procedures and instruments are standardized to allow comparisons among States.</p>
<b>Pregnancy Risk Assessment Tracking System (PRATS)</b>	
<b>Purpose</b>	<b>Methodology</b>
<p>A survey of new mothers regarding mothers' experiences before, during, and after pregnancy. It provides information on the intendedness of pregnancy, prenatal care, health behaviors, breastfeeding patterns, and other issues.</p>	<p>The PRATS methodology is the same as the PRAMS methodology described above. The window of response is 3-12 months postpartum.</p>

<b>Table II-1. Youth Risk Behavior Surveillance (YRBS)</b>	
<b>Behavioral Risk Factor Surveillance System (BRFSS)</b>	
<b>Purpose</b>	<b>Methodology</b>
BRFSS is a health survey of adults in Idaho and includes information about health behaviors (such as alcohol use or cancer screenings), chronic diseases like diabetes, and health care access issues.	The BRFSS is conducted as a random telephone survey of the noninstitutionalized adult population. In order to produce health district estimates, Idaho's sample has grown in size from 600 people in 1984 to approximately 4,900 beginning in 1997. The survey is administered in every month of the calendar year. After annual data collection is complete, individual responses are weighted to be representative of the state's adult population and analysis is performed on the weighted data.
<b>Idaho Substance Use, School Safety, and School Climate Survey</b>	
<b>Purpose</b>	<b>Methodology</b>
The goal of this survey is to evaluate middle and high school students' use and avoidance of alcohol, tobacco, and other drugs; their experiences with substance use education; as well as their perceptions of the school environment, and safety issues such as driving under the influence of intoxicants.	This survey used a stratified random method to select at least 625 students of six grade levels. For each grade level, schools in each of the six state regions were randomly sampled. All students in selected schools were invited to participate. Students and their parents were provided with information about the study to allow them to make an informed, voluntary decision to participate. The survey was first administered in 1998 and has since been administered every 2 years.
<b>Idaho State Smile Survey</b>	
<b>Purpose</b>	<b>Methodology</b>
The Smile Survey is designed to collect statewide data on the oral health of young children in Idaho. Specifically, the survey measures the prevalence of decayed, missing and filled teeth, preventive and restorative needs, and use of sealants.	The Idaho State Smile Survey is conducted once every 5 years on a representative sample of kindergarten, 3rd-grade, and 6th-grade students.
<b>School Health Policies and Programs Study (SHPPS)</b>	
<b>Purpose</b>	<b>Methodology</b>
SHPPS is a national survey that evaluates school health policies and programs at the State, district, school, and classroom levels. Only State level data was used in the current report. The survey focused on eight school health program components: health education, physical education and activity, health services, mental health and social services, food service, school policy and environment, faculty and staff health promotion, and family and community involvement.	State-level data was collected by self-administered questionnaires mailed to designated respondents in state education agencies in all U.S. States and D.C. In cases of missing data, respondents were followed up with additional mail and telephone communication.

<b>Table II-1.</b> <b>Youth Risk Behavior Surveillance (YRBS)</b> <b>School Health Education Profile Survey (SHEPS)</b>	
<b>Purpose</b>	<b>Methodology</b>
SHEPS monitors trends in school health education topics, including sex, substance use, and injury prevention, as well as health education staff training.	One type of questionnaire was administered to school principals to assess school health and environment policies. Another type of questionnaire was administered to lead health education teachers to assess health education instruction. Both questionnaires were mailed to 222 secondary public schools in Idaho containing any of grades 6 through 12 during the spring of 2002.

Data from these and other sources, including past needs assessments from various organizations, were gathered and cataloged in relation to the specific indicators and outcomes to present a complete picture of each MCH or CSHCN population group's needs.

## **B. Primary Data**

Primary data are information directly gathered from the study group. HSR used the examination of secondary data to guide the collection of primary data. The combination of both primary and secondary data completes the picture of MCH population needs and of the status of the delivery system.

A combination of qualitative and quantitative research methods was used to gather the primary data needed. These methods included:

- Key-informant interviews
- Surveys
- Focus groups

It is important to utilize qualitative primary data in the assessment because it permits access to information that is important but not necessarily quantifiable. In short, primary qualitative data can fill out the MCH picture with real-time information and help to put a “face” on the story.

### **1. Interviews with Key Informants**

As described above, interviews with key informants—State officials, providers, health care purchasers, other public-sector stakeholders, and advocates—provided critical qualitative information on the health needs within the State, effectively completing the outline described by the analysis of existing quantitative data. Forty-nine (49) interviews took place over the course of 5 months. The table below describes the types of service providers interviewed.

<b>Table II-2.</b>	
<b>Key Informants by Type:</b>	<b>Number</b>
Direct Service Providers (e.g., hospital birth educator, certified nurse-midwife, school nurse, etc.)	11
Community-based Direct Service Organizations Program Directors (e.g., Migrant Health Council, Parents as Teachers, Head Start, etc.)	9
Medicaid Staff	7
State-level IDHW Program Directors	8
Regional Health and Welfare Directors	3
District Health Office Directors or Program Managers	7
Advocacy Group Directors (e.g., March of Dimes, Idaho Parents Unlimited, etc.)	4

In these interviews, we addressed issues such as:

- The major MCH risks and needs seen by informants in the course of their work
- Services available to address these needs
- Barriers to access to care
- Potential reasons for the persistence of risk factors, health problems, and access barriers affecting specific MCH populations.

To assure the consistency and comparability of information gathered from various sources, the interviews were conducted using structured protocols. To ensure that all relevant issues were covered in the interview, while still allowing room for the expression of individual opinion and experience, the interview guide was designed with unstructured, predominantly open-ended questions. The interview guide is presented in Appendix A.

Following the interviews, summaries were developed that synthesized critical information gathered. Data collected in these interviews was triangulated with data from other sources and examined for consistency.

In addition to the one-on-one interviews, HSR also facilitated a group discussion among participants of the Idaho Perinatal Conference. The title of the hour-long session was *Speaking Out: What Do YOU Think About Maternal Child Health Issues and Needs in Idaho?* The purpose of that discussion was to assess participants' experiences and perceptions regarding screening, referrals, followup care, and other perinatal issues. Approximately 40 health practitioners and policymakers attended the session.

## **2. Surveys to Address Gaps in Data**

Although it is important to learn about MCH needs from the viewpoint and experiences of health care policymakers and providers, it is essential to go directly to the consumers of MCH services

to learn their views and perceptions of MCH needs and experiences using the service delivery system. This is a source of data that does not go through the filter of MCH officials and offers insights that simply cannot be gained through other means. Two methods were used to obtain these data: surveys and focus groups.

The needs assessment team conducted two convenience sample surveys. One was a general Family Health Survey, and one was specific for Families of Children with Special Health Care Needs. These surveys provided a snapshot of the needs and issues confronting families. The surveys also gave families an opportunity to provide structured input into the MCH Needs Assessment process beyond the focus group participation. The survey questions were evaluated through pretests of the survey.

Families could access the Family survey in two ways. A paper version was available through District Health Offices, Parents as Teachers, and the Infant-Toddler Program. The survey was also available online. Members of the MCH Advisory Group, key informants, and other contacts were asked to alert families to the Web site and survey.

The results of the survey are limited to self-selected participants, and not generalizable to all of Idaho. We were not able to capture the needs of people who are currently not accessing services, or do not read English. The surveys were at a ninth-grade reading level in English. Access to the survey required a family to have connections to the health and social system. Unless the family received a paper-based survey, they needed Internet service to complete the Web-based version.

Seven hundred and three (703) families completed the Family Health Survey. Over half of the respondents received or learned about the survey through the District Health Office. Over 90% of respondents lived in Idaho for more than 2 years, and 79% having lived in their city or town of residency for more than 2 years. Most respondents were married (66%) and had a household income of under \$30,000 (67%). Most children had either Medicaid (45%) or Private Insurance (42%); only 7% did not have any health insurance. Additional data is highlighted in Appendix B.

The tables below show where respondents learned about the survey and their demographic characteristics.

<b>Table II-3. Demographic Information of Respondents for Family Health Survey</b>		
	<b>N=703</b>	
<b>Demographic</b>	<b>Number</b>	<b>Percent</b>
<b>Location Where Respondent Received or Learned of Survey</b>		
District Health Office	406	59%
Parents as Teachers	68	10%
Regional Health and Welfare	31	4%
Head Start/Early Head Start	34	5%
Other	151	22%
<b>District</b>		
District 1	112	16%

**Table II-3.  
Demographic Information of Respondents for Family Health Survey**

	<b>N=703</b>	
<b>Demographic</b>	<b>Number</b>	<b>Percent</b>
District 2	102	15%
District 3	24	3%
District 4	192	28%
District 5	17	2%
District 6	220	32%
District 7	26	4%
<b>Age</b>	<b>Number</b>	<b>Percent</b>
<18 Years Old	14	2%
18-30	390	55%
31-50	269	38%
>50	30	4%
<b>Gender</b>	<b>Number</b>	<b>Percent</b>
Male	39	6%
Female	660	94%
<b>Lived in City/Town of Residence</b>	<b>Number</b>	<b>Percent</b>
Under 2 Years	146	21%
2 to 5 Years	158	23%
6 to 10 Years	115	17%
11 to 15 Years	71	10%
Over 15 Years	204	29%
<b>Years in Idaho</b>	<b>Number</b>	<b>Percent</b>
Under 2 Years	49	7%
2 to 5 Years	81	12%
6 to 10 Years	86	12%
11 to 15 Years	97	14%
Over 15 Years	382	55%
<b>Number of Children</b>	<b>Number</b>	<b>Percent</b>
1	233	35%
2	204	30%
3	125	19%
4+	108	15%
<b>Children's Health Insurance</b>	<b>Total</b>	<b>Percent</b>
CHIP	96	7%
Medicaid	643	45%
No Health Insurance	101	7%
Private	598	42%
<b>Health Coverage for Self</b>	<b>Total</b>	<b>Percent</b>
Yes	456	66%
No	232	34%
<b>Marital Status</b>	<b>Total</b>	<b>Percent</b>
Single, Never Married	102	15%
Married	455	66%



<b>Table II-3. Demographic Information of Respondents for Family Health Survey</b>		
	<b>N=703</b>	
<b>Demographic</b>	<b>Number</b>	<b>Percent</b>
Divorced	68	10%
Separated	26	4%
Member of Unmarried Couple	39	6%
Widowed	2	0%
<b>Household Income</b>	<b>Total</b>	<b>Percent</b>
Under \$10,000	165	25%
\$10,001-\$20,000	163	24%
\$20,001-\$30,000	122	18%
\$30,001-\$40,000	80	12%
\$40,001-\$50,000	43	6%
\$50,001-\$65,000	51	8%
>\$65,000	49	7%

One hundred and twelve (112) families with children with special health care needs completed the CSHCN survey. The Children's Special Health program and the Infant-Toddler program were the locations where most respondents learned of the survey. Respondents were asked to indicate the primary insurance for their children with special health care needs (if they had more than one child, they were to indicate for the child with the most medically complicated needs). Just under half (45 percent) of the children had health insurance through the parent or guardian's employer, and 38 percent had Medicaid. The table below describes additional demographic characteristics.

<b>Table II-4. Demographic Information of Respondents for Children's Special Health Care Needs Survey</b>		
	<b>N=112</b>	
<b>Demographic</b>	<b>Number</b>	<b>Percent</b>
<b>Location Where Respondent Received or Learned of Survey</b>		
IPUL	3	3%
Infant-Toddler Program	38	35%
Family Voices	0	0%
Children's Special Health Program	40	37%
School	2	2%
Other	26	24%
<b>Number of Children</b>	<b>Number</b>	<b>Percent</b>
1	25	23%
2	29	27%
3	30	28%
4+	25	24%

<b>Table II-4. Demographic Information of Respondents for Children's Special Health Care Needs Survey</b>		
	<b>N=112</b>	
<b>Children's Health Insurance</b>	<b>Total</b>	<b>Percent</b>
Private Insurance Through Employer	49	45%
Private Insurance Paid by Self	7	6%
Medicaid	41	38%
Katie Beckett	4	4%
Children's Health Insurance Program	5	5%
No Health Insurance	3	3%
<b>Household Income</b>	<b>Total</b>	<b>Percent</b>
Under \$10,000	7	6%
\$10,001-\$20,000	15	14%
\$20,001-\$30,000	23	21%
\$30,001-\$40,000	15	14%
\$40,001-\$50,000	15	14%
\$50,001-\$65,000	16	15%
>\$65,000	11	10%

### **3. *Focus Groups to Obtain Information from the MCH Population Groups on MCH Needs and Experiences Obtaining Services***

Guided focus group discussions have been shown to illuminate issues and answer research questions in more depth than individual interviews because participants within focus groups often respond to ideas and opinions presented by other group members, thereby stimulating a richer set of responses and ideas. Focus groups also are a respectful way of obtaining information from consumers without using forms or surveys that may be off putting. In general, focus groups provide access to people's perceptions in a way that may not be otherwise obtainable.

The focus group facilitators were not based in the State and thus were less likely to be seen by consumers and other stakeholders as having any "hidden agendas" and more as an unbiased group whose goal is to learn about the experiences, beliefs, and concerns of the consumers about MCH issues. Research questions focused on learning about services members of the various MCH population groups have sought and why, what their experience has been in accessing services, and what needs were unmet or inadequately met. The moderator guides are in Appendix C.

HSR analyzed the focus groups using a transcript-based analysis of findings that involved the development of a coding scheme that allowed the project team to assign codes to predominant themes and subthemes of the group discussions.

HSR conducted eight focus groups in several regions of the State. Below is a description of the number of participants by location.

<b>Table II-5.</b> <b>Focus Group Participant By Site of Group</b>	
Focus Group Participants	Number of Participants
<b>Parents of Young Children</b>	
• Caldwell (Conducted in Spanish)	10
• Orofino	10
• Pocatello	9
• Bonners Ferry	7
<b>Parents of Children with Special Needs</b>	
• Twin Falls	8
• Idaho Falls	6
<b>TOTAL Parents</b>	<b>50</b>
<b>Latino Adolescents</b>	
• Nampa	9

<b>Table II-6.</b> <b>Demographic Information of Focus Group Participants</b>		
Demographic	Number (N=50)	Percent
<b>Number of Children</b>		
1	9	18%
2	15	30%
3	14	28%
4	6	12%
5	4	8%
7	1	2%
8	1	2%
<b>Health Insurance for Children</b>		
Yes	38	76%
No	5	10%
Some Children Have, Some Don't	5	10%
N/A	2	4%
<b>Health Insurance for Self</b>		
Yes	30	60%
No	10	20%
N/A	10	20%
<b>Income</b>		
Under \$10,000	8	16%
\$10,001-\$20,000	9	18%
\$20,001-\$30,000	7	14%
\$30,001-\$40,000	6	12%
\$40,001-\$50,000	6	12%
\$50,001-\$65,000	5	10%
>\$65,000	8	16%

<b>Table II-6. Demographic Information of Focus Group Participants</b>		
<b>Demographic</b>	<b>Number (N=50)</b>	<b>Percent</b>
N/A	1	2%
<b>Race/Ethnicity</b>		
White	36	72%
Hispanic	13	26%
American Indian	1	2%
<b>Last Grade Completed</b>		
Less than High School	5	10%
High-school Graduate	6	12%
Some College	16	32%
Associate's Degree	4	8%
Bachelor's Degree	11	22%
Graduate or Professional Degree	6	12%
N/A	2	4%

The following table displays the demographic information for the nine Latino adolescent participants:

<b>Table II-7. Demographic Information for Latino Focus Group</b>	
<b>Demographic Information</b>	<b>Number</b>
<b>Age</b>	
14	2
15	5
16	2
<b>Health Insurance</b>	
Yes	4
Don't know	4
No	1
<b>Saw a Doctor in the Last 12 months</b>	
Yes	7
No	2

## C. Analysis of Primary and Secondary Data

The analysis of both secondary and primary data was structured to permit the examination of the relationships between groups, their needs, and the infrastructure, programs, and capacity in place to address them. The analysis was conducted on a State level—in order to get a “big” picture—but also was conducted on a regional or district level. This analysis will allow for planning for MCH activities at both levels of the health infrastructure system. An important aspect of this task

is the analysis of supportive, complementary, or contradictory data. Because all the secondary data was collected for alternate purposes by different groups with varying levels of rigor, it was analyzed to determine how well it fits together. Data was classified by population, location, collection methodology, and how recent the data was collected.

An analysis of the relationship between needs and infrastructure or services also was conducted. A critical part of the work accomplished under this needs assessment is learning what gaps exist. This critical gap analysis takes the assessment well beyond the documentation of numbers of people with particular issues and moves into other significant areas. These include what types of infrastructure and services are in place to address those needs, who is involved, where there is excess capacity, and where there is insufficient capacity. This analysis permits BOCAPS and its partners to know where intervention efforts are most needed and to develop a concrete plan to work toward the closing of gaps. The analysis examines the size of populations, the location of populations, the services and infrastructure in locations that are appropriate to the population, and finally the differences between the two.

## **D. Mechanisms for Stakeholder Input and Collaboration**

Central to the needs assessment was engaging Idaho stakeholders in the process. The involvement of MCH Advisory Group, the Capacity Assessment for the State Title V (CAST-5) Team, and stakeholder meeting participants was critical to this process. These input mechanisms enabled us to:

- Gather additional data and reports
- Understand the story behind the numbers
- Provide opportunities for feedback and suggestions
- Assess the impact and feasibility factors to be considered in establishing priorities
- Determine potential audiences for the assessment findings and distribution mechanisms
- Begin to develop a plan to implement recommendations.

Below is a description of the role of the stakeholder meetings, Advisory Group, and CAST-5 Team in the assessment process.

### **1. *MCH Advisory Group***

To assure that the assessment truly met the needs of Idaho, HSR developed an Idaho MCH Needs and Capacity Assessment Advisory Group to provide advice, guidance, and “reality checks” to the process. Because they become invested in the process via membership in the Advisory Group, the stakeholders involved in this group were also extremely helpful in disseminating findings and promoting implementation of priorities.

## **2. *Capacity Assessment for State Title V (CAST-5)***

An important element of this assessment is the analysis of the internal capacity of the Division of Health. This was conducted using the CAST-5 Tool developed by the Association of Maternal and Child Health Programs (AMCHP) and the Women's and Children's Health Policy Center at The Johns Hopkins University.

CAST-5 participants included BOCAPS managers, including program directors and other key personnel, representatives from other key Bureaus such as Health Promotions and Health Policy and Vital Statistics, and several other stakeholders who work closely with the Division of Health and could speak to the impact that capacity and State policies have on the broader community.

Although CAST-5 focuses on the State Title V Program, MCH and MCH-related activities also take place in programs outside of Title V. This means that the CAST-5 process produced information that is useful within the context of larger systems and system assessments.

Participants in CAST-5 were asked to self-assess the Division of Health's performance of MCH essential services by rating the adequacy of specific process indicators. The CAST-5 assessment also included components to determine specific resources or capacity needs and to identify strengths, weaknesses, opportunities, and threats associated with the essential services. Synthesis of results of the self-assessment process provided the basis for developing an action plan to address priority needs for enhancing capacity.

## **3. *Stakeholder Meetings***

Three meetings were conducted in three different regions of the State; namely Coeur d'Alene, Boise, and Pocatello. To better assure representation of all significant stakeholders in each of the meetings, the meetings were publicized to community-based organizations, professional associations, consumer and other organizations, BOCAPS programs and constituents, and all key informants. At these meetings, HSR staff described the purpose of the needs and capacity assessments, how the study was conducted and how the information could be used. A discussion of the preliminary findings then followed that included the solicitation of any additional information meeting attendees may have regarding needs and capacity issues.

### **Recommend MCH/CSHCN Priorities to Target Efforts for Improvement**

There are many steps involved in reaching decisions about priorities and many factors to consider in the decision making process. First and foremost, it is important to gather information about the unmet and inadequately met needs of the MCH population and the capacity both available and required to meet these needs. This is the function of the Title V needs assessment: to provide the BOCAPS and its systems partners with the most current and reliable information that is gathered from an array of sources using multiple methodologies. This information allows those charged with making decisions about the allocation of limited resources to begin the process informed about current and projected needs and capacities. This is the information that HSR will provide to BOCAPS in this report.

Clearly it is important to obtain as clear, comprehensive, and well-documented an assessment of unmet and inadequately met needs and of existing capacity as possible to inform the prioritization process. However, need cannot be used in isolation to determine priorities and subsequently drive effective resource allocation. Many other factors are involved in the process of identifying priorities and include the level of public awareness, attitudes, and concerns about the issue. Issues of greater societal concern are more likely than lesser-known issues to be placed on the political agenda. Other factors affecting priority setting include the “doability factor.” Questions to raise about “doability” include: Can something realistically be done about the need? Are there resources available to address the need? If this need is addressed and resources allocated to it, what other needs will remain unmet? If we can mobilize resources to address a need, will our efforts have a meaningful impact? How do we define meaningful impact in terms of the numbers of people affected, opportunities to prevent subsequent problems, the perceived burden of the need on the individual, the community, society as a whole?

The questions raised above must be addressed by Idaho MCH decisionmakers and stakeholders. It is the role of HSR to provide the stakeholders with as much information as possible in formats that are readily understandable and to assist the stakeholders in the priority-setting process. Several strategies were used by HSR to accomplish this, including:

- Stakeholder feedback sessions
- Use of an Idaho MCH Needs Assessment Web site
- Collaboration with MCH systems partners.

The overall strategy regarding dissemination and discussion of the needs assessment findings, recommendations, and priorities was to identify and build on the resources currently in place in Idaho. This serves a twofold purpose. First, it is a cost-effective way to reach as many stakeholders as possible; and second, it facilitates the involvement and investment of a range of stakeholders in promoting MCH in Idaho, helping them to internalize the notion that “MCH is everybody’s responsibility.”